STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395952	A. BLDG: 00 B. WING:	05/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
NAAMANS CREEK COUNTRY MANOR STATE LICENSE NUMBER: **122302**	**1194 NAAMANS CREEK ROAD** **GARNET VALLEY, PA 19060**

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F 0000	INITIAL COMMENT Findings of an Abbreviated Complaint Survey completed on May 9, 2023, at Naamans Creek Country Manor, identified a deficient practices, related to the reported complaint allegations, under the requirements of 42 CFR Part 483, Subpart B Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey process.	F 0000		
F 0684 SS=G		F 0684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0684 SS=G	Continued from page 1 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Preparation and/or execution of this plant of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. Resident 1 physician orders were reviewed by the attending physician. Current residents with active vital sign orders will be reviewed for the past 14 days to verify change in condition MD notification as appropriate. Re-education of the policies following physician orders and change in condition will be completed for licensed staff. DON/Designee will complete random weekly audits X 4 weeks than monthly X 2 to verify that noted	Completion Date: **05/24/2023** Status: **APPROVED** Date: **05/22/2023**

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F 0684 SS=G	Continued from page 2	F 0684	changes in condition are notified to the physician. Results of the audits will be forwarded to the monthly QAPI committee for review and recommendations x 3 months.	

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F 0684 SS=G	Continued from page 3 Based on a review of the facility's policy, clinical records, and staff interviews, it was determined that the facility failed to follow physician's order to monitor the resident's vital signs and to timely notify the physician of an abnormal blood pressure reading resulting in actual harm of hospitalization for one of three residents reviewed (Resident 1). Findings include: Review of the facility's policy titled "Vital Signs, Frequency", May 2022, revealed that upon "admission or readmission of a resident to the facility, vital signs will be obtained every shift for 72 hours to establish baseline vital signs. Vital signs will be obtained and documented per physician's orders, as a nursing measure and/or pharmacy recommendations." Review of the facility's policy titled "Change in Resident Condition/Notification", dated March 2022, revealed that "the facility must evaluate each	F 0684		

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F 0684 SS=G	Continued from page 4 resident's significant change in condition and notify the attending physician appropriately of the evaluation on time." Review of Resident 1's diagnosis list revealed Chronic Obstructive Pulmonary Disease (COPD-group of lung diseases that blocks airflow and make it difficult to breathe), Acute Respiratory Failure, Pneumonia (infection that inflames the air sacs in one or both lungs), and Dementia (group of symptoms affecting memory, thinking and social abilities severely enough to interfere with daily life). Review of Resident 1's clinical records revealed "Admission/Readmission" nursing documentation dated April 18, 2023, revealed resident was readmitted to the facility from the hospital on April 18, 2023, at 6:50 p.m., with a diagnosis of Pneumonia (infection of the air sacs in one or both the lungs. Characterized by severe cough with phlegm, fever, chills and difficulty in breathing). Vital signs documented as follows: Blood Pressure (B/P) was 140/73 mm Hg; heart rate (HR) was 81 BPM;	F 0684		

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F 0684 SS=G	Continued from page 5 respirations 18/min.; and oxygen saturation was 95%. Review of the physician's order dated April 19, 2023, at 7:00 a.m., revealed an order for vital signs every shift x 72 hours then monthly everyday shift for three days; to start on April 19, 2023, at 7:00 a.m. Review of the resident's clinical records revealed that the resident's B/P was not taken on the morning shift (April 19, 2023 7a.m.-7p.m) and night shift (7p.m.-7a.m. on April 19th into April 20, 2023). Heart Rate (HR), respirations, and temperature were not taken on the morning shift. Interview with the licensed nurse Employee E3 conducted on May 4, 2023, at 11:00 a.m., revealed that vitals which include B/P, HR, RR (Respiratory Rate), and temperature should have been checked every shift as ordered and the result should be documented on the resident's clinical records. Employee E3 confirmed that there was no	F 0684		

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F 0684 SS=G	Continued from page 6 documentation of Resident 1's blood pressure from April 19, 2023, at 7:00 a.m., until April 20, 2023, at 4: 22 p.m. Review of Resident 1's nursing progress notes by licensed Employee E4 dated April 20, 2023, at 4:59 p.m., revealed at 4:00 p.m., the "resident's oxygen via nasal cannula was not on while the resident was sleeping, V/S normal, Spo2 100%. The daughter reported that she forgot to put it back on after readjusting her, daughter was educated." Review of the vitals and weights dated April 20, 2023, at 4:22 p.m., documented by Employee E4 revealed a blood pressure of 83/55 mm Hg (normal B/P range from 90/60-120/80 mm Hg), Pulse Rate (PR) -82, Respiration Rate (RR)-18, Temperature (T)-97.4 F, and Oxygen level (Spo2) was 100%) Review of Resident 1's clinical records failed to reveal the resident was comprehensively assessed after noting a blood pressure of 83/55 mm Hg at 4:22 p.m. Further review of the clinical records	F 0684		

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F 0684 SS=G	Continued from page 7 failed to reveal the physician was notified of the resident's low blood pressure. Review of the nursing progress notes dated April 20, 2023, at 7:21 p.m., revealed the resident's granddaughter requested the resident be transferred to the hospital for evaluation because the resident had decreased responsiveness and was not talking or interacting with the family. The physician was notified. Review of the progress notes dated April 20, 2023, at 8:00 p.m., revealed resident physician ordered the transfer of the resident to the hospital for evaluation due to a change in mental status, and lethargy. Review of the progress notes dated April 21, 2023, at 2:46 a.m., revealed staff "spoke to the ER (Emergency Room) nurse and reported that the resident was admitted with hypotension (low blood pressure) and that they were having a difficult time trying to keep the patient's blood pressure up."	F 0684		

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F 0684 SS=G	Continued from page 8 Review of the hospital records dated April 21, 2023, revealed the resident was transferred to the hospital for hypotension and was, in fact, hypotensive upon arrival and received sepsis (blood infection) fluid challenge with the improvement of blood pressure. The resident was admitted to PCU (Progressive Care Unit) with a diagnosis of Sepsis. Interview with Employee E4 conducted on May 4, 2023, at 1:00 p.m. revealed Employee E4was not able to answer any questions asked by the surveyor. Employee E4 reported that she/he was an agency. Employee E4 stated, "I do not know what you are talking about". "I don't remember at the top of my head". "I'm sorry, I can't speak on it". Interview with licensed nurse Employee E5 conducted on May 4, 2023, at 1:15 p.m. Employee E5 reported that she/he was the nursing supervisor from 3:00 p.m., until 11:00 p.m., on April 20, 2023. Employee E5 reported not getting any concerns/reports regarding the resident's condition	F 0684		

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F 0684 SS=G	Continued from page 9 until around 7:00 p.m., when staff notified her/him that Resident 1's granddaughter wanted to talk to the nursing supervisor, or she will call 911 herself for the resident to be transferred to the hospital. Employee E5 reported that the resident was noted to be very sleepy, the family requested for the resident to be transferred to the hospital for evaluation, so she/he called the on-call physician and prepared a paper works for transfer. Employee E5 reported that Employee E6 handed her Resident 1's vital sign list but she/he did not get to ask when it was taken. Employee E5 reported that the blood pressure noted was in the "80's". Employee E5 reported that the physician called back and gave orders to transfer the resident to the hospital, 911 was called, the resident left, and the family followed. Review of the transfer form completed by Employee E5 on April 20, 2023, at 7:32 p.m., revealed the same vital signs taken on April 20, 2023, at 4: 22 p.m. There was no record that Resident 1's vitals were re-checked after 4:22 p.m.	F 0684		

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F 0684 SS=G	Continued from page 10 An interview with licensed nurse Employee E6 was conducted on May 4, 2023, at 1:45 p.m. Employee E6 reported that she/he was the nurse on April 20, 2023, from 7:00 p.m., until 7:00 a.m., the next day. Employee E6 reported that her/his shift starts at 7:00 p.m., and during the report, the morning (agency) nurse reported that the family was requesting for the resident to be transferred to the hospital, that vital signs were taken, and it was fine, and the nursing supervisor was already notified. Employee E6 was unable to remember the resident's vital signs reported by the morning nurse and reported that she/he might have written it on her/his report paper, but it was already thrown out. Employee E6 reported checking the resident and noted that the resident was "gazing and not talking". Employee E6 reported that she/he did not check the resident's vitals, and the nursing supervisor sent the resident to the hospital. Interview with the Nurse Practitioner was conducted on May 4, 2023, at 2:00 p.m. The Nurse Practitioner (NP) reported that she was present on	F 0684		

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F 0684 SS=G	Continued from page 11 April 20, 2023, and was on-call until 5:00 p.m. The NP confirmed not getting a call regarding Resident 1's low blood pressure taken at 4:22 p.m., the NP reported that an order would have been made if she/he was notified regarding the resident's low blood pressure. The facility was unable to determine how long the resident had been having low blood pressure since the order to monitor the resident's blood pressure (vitals) ordered on April 19, 2023, at 7:00 a.m., was not followed. The facility was unable to provide an explanation why the physician was not notified of Resident 1's blood pressure of 83/55 mm Hg on April 20, 2023, at 4:22 p.m., and no documentation that the resident was comprehensively assessed. The physician was only notified of the resident's condition upon the family's request to transfer the resident to the hospital. The facility failed to follow the physician's order to	F 0684		

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F 0684 SS=G	Continued from page 12 monitor blood pressure/vitals and failed to timely notify the physician of the resident's low blood pressure which resulted in harm to Resident 1 of hospitalization. 28 Pa. Code 211.5(f) Clinical records Previously cited 7/22/22, 6/28/21 28 Pa. Code 211.10 (c) Resident care policies Previously cited 7/22/22 28 Pa. Code 211.12(d)(1)(5) Nursing services Previously cited 7/22/22, 6/28/21 28 Pa. Code 201.14(a) Responsibility of licensee Previously cited 6/28/21	F 0684		

Certified End Page

NAAMANS CREEK COUNTRY MANOR

STATE LICENSE NUMBER: 122302

SURVEY EXIT DATE: 05/09/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY